



# KENTUCKY EMPLOYEES' HEALTH PLAN

## ENROLLMENT APPLICATION FOR THE JUDICIAL/LEGISLATORS RETIREMENT PLANS

### PY 2010

**Mail application to:**

KY Judicial Form  
Retirement System  
305 Ann Street, Rm 302  
Whitaker Bank Bldg.  
Frankfort, KY 40601

**INSURANCE COORDINATOR SECTION**

/  /  2010  
Coverage Effective Date

Company Number

**Reason for Application:**

☐ < New Retiree ☐ < Open Enrollment ☐ < QE\* ☐ < Previously Waived\* ☐ < Other\*

\* If you previously waived, or marked "Other" or "QE" above, enter the Qualifying Event date \_\_\_\_\_  
AND a description of the Qualifying Event: \_\_\_\_\_ Date \_\_\_\_\_ Qualifying Event Description \_\_\_\_\_

**Additional Information:** ☐ < I am covered under Medicare Supplemental Plan through a state sponsored retirement system.  
☐ < Retiree return to work

### SECTION I: DEMOGRAPHIC INFORMATION

Is retiree applying  
for this coverage?

☐ < Yes

☐ < No

If "No", what is your relationship to  
the retiree?

-   -

**RETIREE SSN** (Required)

**RETIREE Name** (First, MI, Last)

-   -

**APPLICANT SSN** (If retiree is not applying)

**APPLICANT Name** (First, MI, Last)

**APPLICANT Specific Information**

Mailing Address \_\_\_\_\_

/   /      
Date of Birth (MM/DD/YYYY)

City, State, Zip Code \_\_\_\_\_

County of Residence \_\_\_\_\_

Country / Mail Code, if not USA \_\_\_\_\_

**Smoking Status (Required)**

Have you smoked  
in the last 2 months? ☐ < Yes ☐ < No

**Gender**

☐ < Male

☐ < Female

**Marital Status**

☐ < Married

☐ < Single

**SECTION II: PLAN ELECTION-** If waiving (i.e. decline) health insurance coverage, go to Section IV.

<b>1. Option</b> (Check only one) <input type="checkbox"/> < Commonwealth Standard PPO <input type="checkbox"/> < Commonwealth Capitol Choice <input type="checkbox"/> < Commonwealth Optimum PPO	<b>2. Level of Coverage</b> <input type="checkbox"/> < Single <input type="checkbox"/> < Parent Plus <input type="checkbox"/> < Couple <input type="checkbox"/> < Family	<b>3. Cross-Reference Payment Option</b> <b>NOT APPLICABLE</b>
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**SECTION III: SPOUSE AND/OR DEPENDENT INFORMATION** → If you elected Single coverage, skip to Section VI

Social Security Number	Name (First, MI, Last)	Gender (Circle one)	Date of Birth (MM/DD/YYYY)	Relationship Code
		M F		
		M F		
		M F		
		M F		

Relationship Codes: SP = Spouse, CH = Child, DD = Disabled Dependent, CO = Court-Ordered Dependent

PY 2010

-  
Retiree's SSN

-  
Applicant's SSN (from Page 1, Section I)

#### SECTION IV: WAIVER

Do you wish to waive (i.e. decline) your Health Insurance Coverage? ☐ < Yes

#### SECTION V: FLEXIBLE SPENDING ACCOUNTS (FSA)

**Not Applicable** → Retirees are not eligible to participate in a Flexible Spending Account.

#### SECTION VI: AUTHORIZATION AND CERTIFICATION

- \* I understand that my signature on this application creates a legal and binding contract between myself, my retirement system, the Department of Employee Insurance and any TPA.
- \* I understand that each dependent I am enrolling meets the eligibility requirements of a dependent as set forth in the plan document and in the KEHP handbook.
- \* I understand that this plan has a tobacco incentive for members who do not use tobacco and that this plan offers tobacco cessation programs.
- \* **I elect to have the employee contribution for health coverage deducted on a pre-tax basis unless I sign a Post-Tax Form or otherwise acknowledge post-tax treatment for my dependents. For Pre-tax treatment, dependent coverage must meet eligibility requirements of section 152.**
- \* I authorize the release of medical claims data to the Retirement System for the use in data analysis and referral to available health related services upon their review.
- \* I must abide by the terms and conditions governing membership and receipt of services from the plan in which I have enrolled and agree to do so.
- \* I understand that the elections indicated on the application may not be change during the plan year, with the exception of certain Qualifying Events.
- \* I authorize my Retirement System to deduct from my retirement benefits the amount required to cover my share of the coverage I have selected including any arrears I may owe.
- \* I authorize the Retirement System to release the information in this application to the Social Security Administration. The information in this application may be used by the Social Security Administration to determine Medicare eligibility. I further acknowledge that Medicare eligibility may affect my participation in the Kentucky Employees Health Plan.
- \* I understand that the misrepresentation of any information on this application with the intent to defraud is a fraudulent insurance act, which is a crime, and any material misrepresentation or omission may be used to reduce or deny a claim or to terminate my coverage.
- \* This plan has a tobacco incentive for members who do not use tobacco and that this plan offers tobacco cessation programs.
- \* I have fully read the materials provided to me. My signature below certifies that the statements on this form are true and complete to the best of my knowledge. I acknowledge and understand that DEI will comply with the HIPAA rules and that disclosure of information will be done under the rules of such Federal Law. I further authorize DEI to use such information and to disclose such information to third party administrators, vendors, consultants, governmental with jurisdiction and other necessary parties when necessary for my care or treatment, payment for services, the operation of my health plan or to conduct related activities.
- \* I understand that any person who knowingly, and with the intent to defraud any insurance company or other person, files an application for I insurance containing any forged signature or incorrect signature date thereto commits a fraudulent insurance act, which is a crime. I understand that I can be held responsible for any fraudulent act that is the result of a forged signature or incorrect signature date that I could have prevented while acting within my duties related to the KEHP and it may be used to reduce or deny a claim or to terminate my coverage. My signature below certifies that all information, signatures and signature dates affixed to this contract are correct to the best of my knowledge.

Retiree Signature

Date

Applicant Signature (if other than retiree)

Date

Retirement Insurance Coordinator Signature

Date